

Combat and Operational Stress: Minimizing its Adverse Effects on Service Members

**A Monograph
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Abstract

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Stress and stressors are an inherent part of warfare because of the violence, the physical conditions, and duration of operations. It has been studied and documented that some stresses are good for an individual because they improve performance. Stress represents “the mobilization of the body and mind to counteract stressors.”¹ It can be positive or negative. A stressor is any event or situation that requires an unusual change in the way a person responds.

This study looks at why the military is reactive in its battle against combat and operational stress and how it can become proactive. The study examines not only the adverse impact on a soldiers’ performance in a stressful combat or operational environment, but it also addresses the individuals ability to function once he/she is no longer in a stressful combat or operational environment. Early identification at the onset of short-term effects provides a window to properly treat and minimize the negative effects of handle Combat and Operational Stress (COS). It has become evident that more attention is being given to service members that return from combat with PTSD. However, a more effective use of resources can be achieved by providing a basic education which identifies what combat and operational stress is and how we can minimize its short and long- term negative effects. This in turn can minimize the number of service members that need to be treated for long-term medical conditions that develop because of COS.

This study examines how we can better prepare U.S. service members to handle Combat and Operational Stress.² This paper addresses ways to minimize the adverse effects of COS. Adverse refers to physical, mental, and emotional manifestations; loss of personnel due to combat ineffectiveness; misconduct stress behavior; and other short- and long-term conditions produced by combat stress. These adverse effects are known as maladaptive stress reactions. To determine

¹ Department of Health Promotion and Wellness “Stress and Combat Performance” Issue 22-002-0499. . U.S. Army Center for Health Promotion and Preventive Medicine, Washington, D.C.: Government Printing Office.

² U.S. Department of the Army, FM 6-22.5: *Combat and Operational Stress* (Final Draft). Washington, D.C.: Government Printing Office, December 2006.

this a few questions are asked. What has the military done in the past concerning combat stress and was it successful? What does current military doctrine say about combat stress and how effective is that doctrine? How has the doctrine been implemented in the past? What can be done to ensure better and complete treatment for combat stress in the future?

An examination of military doctrine on combat stress reveals that a set of guidelines has typically been published at the conclusion of wars or conflicts. Additionally, looking at the study of combat stress from a historical perspective the educational focus has trended towards civilian and military medical professionals, and the military's chaplaincy. While this group forms the bedrock for evaluating and treating combat stress, the education of soldiers and leaders has proven insufficient.

This paper addresses prevention rather than treatment. It postulates that if a program incorporating education, training, and phased prevention is developed and integrated, then the military can minimize the negative effects of combat and operational stress in its service members.

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Introduction

Problem Definition

Today, our military finds itself in a reactive posture as it relates to combat and operational stress. This is evidenced by the presentation of briefings to service members which focus on identifying long-term conditions such as Post Traumatic Stress Disorder (PTSD). In mid-2007, the Army directed that all soldiers receive a briefing on PTSD and Mild Traumatic Brain Injury (MTBI); however, no such directive has been given concerning COS. This is equivalent to teaching someone algebra or some other advanced math without first teaching them the basic. PTSD does not just magically appear; rather the condition develops because of exposure to COS. Military hospitals display signs that give basic information about PTSD and the availability of help if you know someone or think you might suffer from this condition. The Army has set-up a PTSD site within the Army Knowledge Online website. This begs several questions. Where are the signs that talk about combat stress which is a prerequisite for developing PTSD? What efforts are underway to address the issue of combat and operational stress on a massive level? Instead of dealing with the precursor (combat and operational stress) to a long-term condition (PTSD) the military has almost exclusively focused on dealing with the long-term condition. The military has focused on treatment rather than prevention. Service members that may suffer from PTSD need to be identified and treated. However, if the military expects to get ahead of the proverbial power curve the focus needs to expand to include educating service members before they conduct combat and other operations that induce stress, and developing a prevention program.

This paper will address ways to minimize the adverse effects of COS. Adverse refers to physical, mental, and emotional manifestations; loss of personnel due to combat ineffectiveness; misconduct stress behavior; and other short- and long-term conditions produced by combat stress.

These adverse effects are known as maladaptive stress reactions. To determine this a few questions must be asked. What has the military done in the past concerning combat stress and was it successful? What does current military doctrine say about combat stress and how effective is that doctrine? How has the doctrine been implemented in the past? What can be done to ensure better and complete treatment for combat stress in the future?

This paper addresses prevention rather than treatment. It postulates that if a program incorporating education, training, and phased prevention is developed and integrated, then the military can minimize the negative effects of combat and operational stress in its service members.

Significance of the Study

The purpose of this study is to examine how we can better prepare U.S. Service Members to handle Combat and Operational Stress (COS).³ This study will look at why the military is reactive in its battle against combat and operational stress and how it can become proactive. The study examines not only the adverse impact on a soldiers' performance in a stressful combat or operational environment, but it also addresses the individuals ability to function once he/she is no longer in a stressful combat or operational environment. Figure 1 provides a list of the positive and negative impact that combat and operational stress can have on an individual. The delineation between short-term and long-term outcomes (effects) is important because it demonstrates the importance of identifying and treating individuals in order to decrease the chances of long-term effects developing. Early identification at the onset of short-term effects provides a window to properly treat and minimize the negative effects of COS. It has become evident that more attention is being given to service members that return from combat with PTSD. However, a

³ U.S. Department of the Army, FM 6-22.5: *Combat and Operational Stress* (Final Draft). Washington, D.C.: Government Printing Office, December 2006.

more effective use of resources can be achieved by providing a basic education which identifies what combat and operational stress is and how we can minimize its short and long- term negative effects. This in turn can minimize the number of service members that need to be treated for long-term medical conditions that develop because of COS.

Ways to minimize the negative effects of combat and operational stress include physical fitness, tough, realistic, and challenging training; education of service members prior to combat and/or operational deployments which will give them an awareness; functional Family Readiness/Support Groups; decompression after conducting combat and/or operational missions; and access to care and outlets during post-combat and/or operational deployments. This is by no means an exhaustive list, but it is a basic list of how the military can help reduce long-term combat and operational stress reactions. These means in turn can produce positive reactions to COS.

Finally, there is an understanding that it will take time to judge the effectiveness of instituting changes that focus on prevention. The potential exists that the cumulative effects of multiple deployments may decrease the effectiveness of these changes. As an example, it is not the first day of a field exercise that should concern a commander. Rather, it is day number six when soldiers have been in constant motion, had little food, and decreased rest. In this group lies the soldier more likely to become a heat casualty. In this example, failure of the command to recognize problems early on and institute preventive measures only exacerbates the potential for catastrophic outcomes. The same holds true for our service member in the sense that it is not necessarily the first deployment that will cause problems, but it is the second, third, or fourth deployment because of the gradual degradation of resistance to combat and operational stress. Each individual has a breaking point. In some cases they break fast, in others they break gradually, and in some they improve initially only to break in the end. The fundamental fact remains we must do everything we can prior to deployment, especially the first one, to give our service members the best chance to deal with and avoid the negative effects of COS.

FIGURE 1: Lists of short-term and long-term outcomes of combat and operational stress reaction (COSR)⁴

Short-Term Outcomes (Effects)	Long-Term Outcomes (Effects)
<ul style="list-style-type: none"> • Adaptive Stress Reactions (+) • Maladaptive stress reactions • Combat and operational stress reactions • Misconduct stress behaviors • Behavioral Disorders • Suicide/homicide 	<p>Occupational</p> <ul style="list-style-type: none"> • Adaptive Stress Reactions (+) • Impaired/Deviant performance • Excessive Medical care • Involuntary separation/attrition <p>Social</p> <ul style="list-style-type: none"> • Aggression/withdrawal/avoidance <p>Family</p> <ul style="list-style-type: none"> • Marital discord • Hostility/violence

This is not a paper about PTSD, although the subject will be mentioned when appropriate. It is not designed to focus on the medical aspects e.g. white blood cells count, psychophysical changes, chemical releases within the brain, etc. It will not look at the impact of combat and operational stress on family members in great detail; however, it acknowledges that COS does impact families as well. This paper is a recommendation for how the military can become proactive in its efforts to minimize the destructive power of combat and operational stress on service members and prevent long-term stress casualties.

⁴ U.S. Department of the Army, Field Manual 4-02.51: *Combat and Operational Stress Control*, Washington, D.C.: Government Printing Office, June 2006, 1-3.

Background and Definitions

“Study of warfare in classical times yields some important lessons. First, the ancient world recognized the power of combat to alter behavior by means other than direct killing. Second, the effects of combat could transcend the battle itself and affect people long after the fight. Third, the dependence of members of the unit on each other [for survival]...”⁵ The Greeks are known for their use of the phalanx in the 8th century B.C. This formation was based on infantrymen maintaining a close, tight and disciplined formation. The close proximity served to decrease the fear and anxiety of the impending battle among the members of the formation. “Part of the Greek phalanx’s power was its psychological effect on the enemy: Its sound and appearance could so frighten opponents that they would flee.”⁶ The success of the formation required a high level of cohesion and discipline, and illustrated the interdependence of each member of the unit.

Stress and stressors are an inherent part of warfare because of the violence, the physical conditions, and duration of operations that make up the nature of war. It has been studied and documented that some stresses are good for an individual because they improve performance. Stress represents “the mobilization of the body and mind to counteract stressors.”⁷ Stress as an inherent part of life and can be positive or negative. A stressor is any event or situation that requires an unusual change in the way a person responds. It is often unfamiliar or creates conflict among motives within a person. There are two types of stressors: mental and physical. A physical stressor has a direct impact on the body and includes both environmental and physiological conditions. A mental stressor is one in which information impacts the brain with no physical

⁵ David H. Marlowe. *Psychological and Psychosocial Consequences of Combat and Deployments with Special Emphasis on the Gulf War*. RAND, 2001, xviii.

⁶ Idib., xviii.

impact on the body. It includes both cognitive (psychological) and emotional reactions to stressors. Figure 2 contains a list of examples of physical and mental stressors.⁸ Eustress, stress in its positive form, is the degree of stress that helps sustain and improve tolerance to stressors without causing an unusual reaction. Eustress helps the body and mind function better and cope with stressors. Adaptive Stress Reaction is the positive response that occurs when stressors are combined with effective leadership and good relationships with peers which enhances both individual and unit performance under stressful conditions.

⁷ Department of Health Promotion and Wellness “Stress and Combat Performance” Issue 22-002-0499. . U.S. Army Center for Health Promotion and Preventive Medicine, Washington, D.C.: Government Printing Office, 1.

⁸ Ibid., 1.

FIGURE 2: Examples of combat and operational stressors⁹

PHYSICAL STRESSORS	MENTAL STRESSORS
ENVIRONMENTAL	COGNITIVE
Heat, cold, wetness, dust	Information (too much/too little)
Vibration, noise, blast	Sensory overload or deprivation
Noxious odors (fumes, poisons, chemicals)	Ambiguity, uncertainty, unpredictability
Directed-energy weapons/devices	Time pressure or waiting
Ionizing radiation	Difficult decision (rules of engagement)
Infectious agents	Organizational dynamics and changes
Physical work	Hard choices versus no choice
Poor visibility	Recognition of impaired functioning
Difficult or arduous terrain	Working beyond skill level
High altitude	Previous failures
PHYSIOLOGICAL	EMOTIONAL
Sleep deprivation	New to the unit, isolated, lonely
Dehydration	Fear and anxiety producing threats (of death, injury, failure, or loss)
Malnutrition	Grief-producing loss (bereavement)
Poor hygiene	Resentment, anger, rage-producing frustration and guilt
Muscular or aerobic fatigue	Inactivity producing boredom
Over- or under-use of muscles	Conflicting/dividing loyalties
Impaired immune system	Spiritual confrontation or temptation causing loss of faith
Illness or injury	Interpersonal conflict (unit, buddy)/ Loss of privacy
Sexual Frustration	Home-front worries, home sickness
Substance use (smoking, caffeine, alcohol)	Victimization/harassment
Obesity/Poor physical condition	Exposure to combat/dead bodies/Having to Kill

⁹ FM 4-02.51, 1-4

Maladaptive Stress Reaction occurs when a person reaches their breaking point. Maladaptive Stress Reaction includes combat and operational stress reaction (COSR) and misconduct stress behaviors. COSR is applied to any stress reaction in a military environment. They are only transient reactions to the traumatic stress of combat and cumulative stresses of military operations.¹⁰ They can impact an individual both physically and mentally. Misconduct Stress Behaviors range from minor breaches of unit orders or regulations to serious violations of the Uniformed Code of Military Justice (UCMJ) and the Law of Land Warfare. Examples include substance abuse, brutal violence, recklessness, desertion, malingering, and fraternization. Other negative reactions include physical fatigue, mental fatigue, and battle fatigue. Physical fatigue is weariness and/or decreased performance capability due to hard or prolonged worked/effort, muscle tiredness, aerobic fatigue, and sleep deprivation. Physical illness and intense emotions can produce fatigue. Mental fatigue is impaired performance due to continued mental effort on a specific task. Emotions, such as boredom or uncertainty, also produce mental fatigue. Battle fatigue/combat stress reaction is produced by both physical and mental tasks.¹¹ Figure 3 provides a list of both adaptive and maladaptive stress reactions. Notice that the field manual implies that negative long-term reactions can still develop even though positive short-term responses are generated while an individual is in a stressful environment.

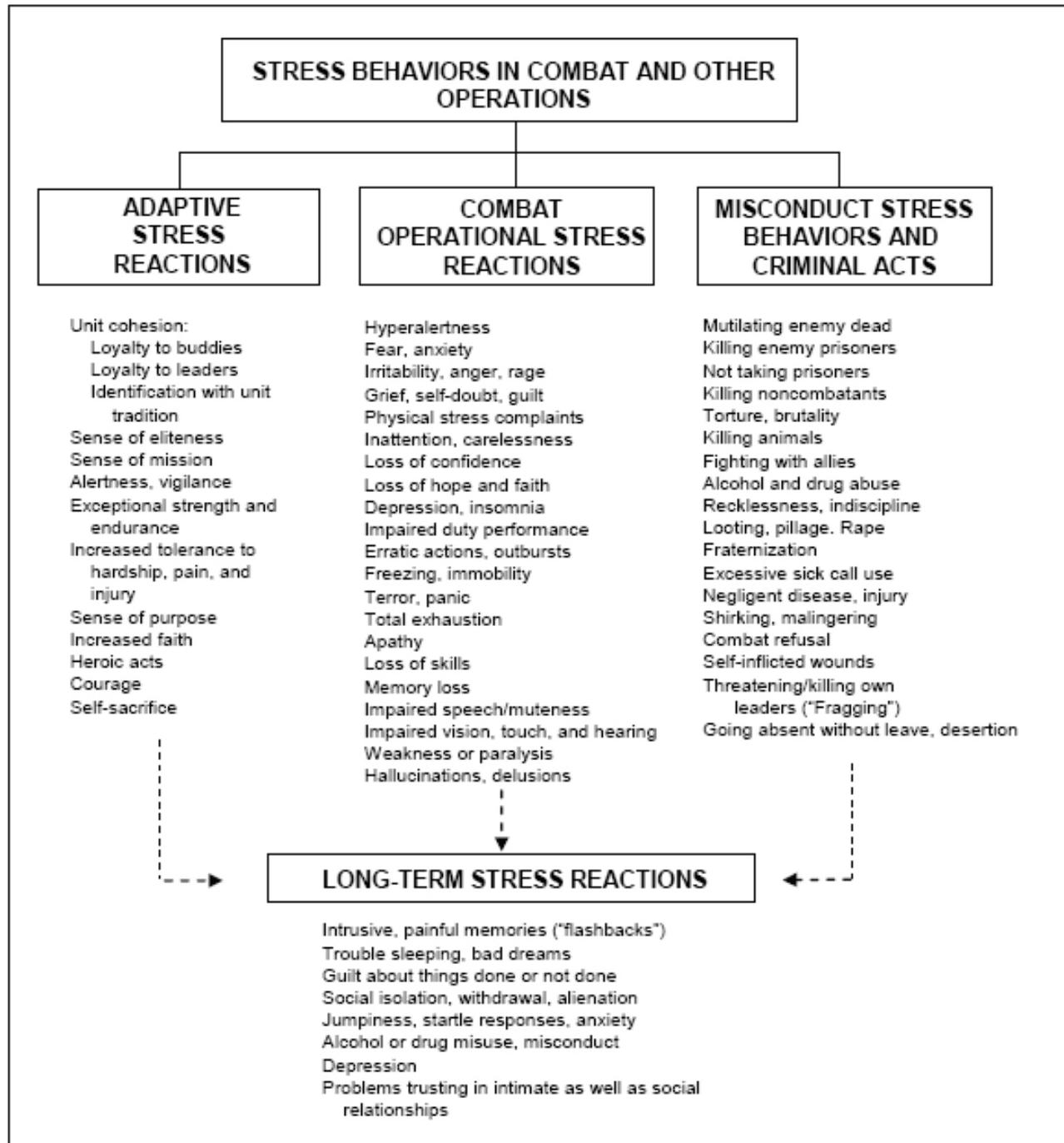
This paper will examine what our military has done in the past and what it is doing now to address combat and operational stress. Where has the focus been as far as educating different groups about COS? The first section looks at the major wars and conflicts the United States military has participated in during the 20th century and its means of dealing with combat stress. These wars/conflicts will be examined to provide a historical context of the military's quest to

¹⁰ Ibid., 1-5.

¹¹ Department of Health Promotion and Wellness. "Stress and Combat Performance," Issue 22-002-0499.

understand, prevent, and minimize the effects of combat stress. The Interwar Years are examined to show the continuity or lack of continuity within the military in its understanding and treatment of combat stress. The next section will look at past and present military doctrine on combat stress and what the current doctrine proposes concerning combat stress. It will discuss the important role that leaders must play if we expect to effectively mitigate the negative effects of combat and operational stress. The third section will look at the first phase of Operation Iraqi Freedom when it was a conventional fight. The fourth section will examine a potential concept that may help the military assume a proactive posture. The fifth section will provide recommendations on how the military as an institution can become proactive in its efforts to prevent combat and operational stress from producing long-term stress casualties both now and in future operations. The final section provides recommendations for further research and papers.

FIGURE 3¹² : Stress Behaviors in combat and other operations



¹² FM 4-02.51, 1-6.

Historical Context

Unlike a physical wound produced by a bullet or artillery round, combat stress does not necessarily produce any visible wounds on its victim. Yet, the impact of combat stress can be just as devastating as wounds produced by munitions. Combat stress has received many labels since the First World War. These labels include “shell shock, war neurosis, psychoneurosis, combat fatigue, combat reaction, stress reaction, battle stress reaction, battlefield fatigue, and battlefield stress.”¹³ All these labels were an attempt to characterize and comprehend what happens to an individual on the battlefield when stress enters the negative realm and begins to adversely impact a soldier’s performance. These manifestations are known as combat stress reactions. It is important to note that names matter. Shell shock, the name given to psychological casualties as a result of the artillery barrages on the trenches during World War I, was considered an acceptable or soldierly term for its victims because there was a direct correlation between the physical condition and the blast/concussive over-pressure. Conversely, the terms war neurosis and psychoneurosis carried an inherently negative connotation because they implied by their name that a mental illness or disorder existed. The victims, their fellow soldiers, and society did not consider these terms acceptable or soldierly and therefore it produced a negative effect within individuals and units. The types of operations, sustained or continuous, the duration, duration of exposure to high levels of stress, and sleep levels played an important role in soldiers’ reaction to COS.

¹³ Dale B. Flora. *Battlefield Stress: Causes, Cures, and Countermeasures*. Fort Leavenworth: U.S. Command and General Staff College, 1985, 11-12.

World War I

World War I marked the beginning of the study of combat stress by civilian and military medical professionals alike. This war started out as a war of movement during which few combat stress casualties were observed. As the war changed to trench warfare an unexplainable phenomenon began to significantly impact the combat effectiveness of soldiers. World War I demonstrated the earliest attempts to understand the effects of combat stress on individuals. The first official term to define the physical and psychological effects of war was created in order to explain the new phenomenon. The term shell shock was used initially because it characterized the state and condition of soldiers “after intensive shelling.....with no neurological reason” to explain the change.¹⁴ Shell shock produced numerous casualties which forced the military to seek an explanation. Dr. Rivers, a Royal Army Medical Corps Officer, stated that his dilemma was “how to convince a romantic officer corps that shell shock reflected the reaction of normal men to abnormal circumstances, rather than lack of character.”¹⁵ This statement reflects the beginnings of the negative stigma that became attached to individuals who became combat stress casualties.

In 1916, the term war neurosis replaced shell shocked as the number of combat stress casualties continued due to different combat conditions. The old term, shell shock, was now inadequate because it did not account for the new enigma that continued to cause adverse combat stress reactions without a direct cause. This name change also had negative a impact of the perception of both soldiers that suffered from war neurosis and members of the soldier’s unit.

¹⁴ Larry H. Ingram and Fredrick J. Manning, “Psychiatric Battle Casualties: The Missing Column in a War Without Replacements,” Military Review, LX (August, 1980), 22.

¹⁵ Fuschak, 5. This paper details the medical facility set-up for British officers that became combat stress casualties during WW I.

Because war neurosis exhibited similar symptoms as civilian neurosis, it allowed civilian and military medical personnel to properly diagnose and treat these casualties.¹⁶

Numerous, continuous and sustained operations were conducted throughout the duration of World War I. There were high levels of intensity with little to no opportunity to rest and refit. The high number of stress casualties limited units' ability to accomplish their mission. British and French medical personnel experimented through trial and error to determine how to mitigate losses in manpower due to combat stress. "When the United States committed forces to the war, American psychiatrists confirmed and used the treatment procedures developed by the British and French."¹⁷ The end result was military medical personnel were able to utilize civilian medical knowledge as it developed a foundation of knowledge on combat stress reaction in individuals. As WW I neared its conclusion, there was better treatment for combat stress casualties and a better return to duty rate. These were made possible because of collaboration between civilian and military medical personnel and proper diagnosis. However, misunderstanding and the negative stigma remained among non-medical personnel. This misunderstanding was displayed by the execution of "well over three hundred [soldiers] for desertion and cowardice" by the British at the conclusion of the war when in actuality these individuals were combat stress casualties.¹⁸

WWI marked the beginning of the military's attempt to identify and counter the destructive effects of combat stress. Society frowned on men expressing what they perceived to be fear or cowardice. "World War I taught us that each war interacts with the beliefs of the wider popular culture and medical and psychological knowledge and beliefs of the time."¹⁹

¹⁶ Ibid., Page 22.

¹⁷ Flora, Page 21.

¹⁸ Fuschak, Page 5.

¹⁹ David H. Marlowe. *Psychological and Psychosocial Consequences of Combat and Deployment with Special Emphasis on the Gulf War*. Santa Monica, CA: RAND, 2001, 41.

Interwar Years

During the interwar years civilian psychologists and theorists had a profound impact on the military's rationale for dealing with combat stress and soldiers. This period witnessed "the development and spread of the concepts and assumptions of depth psychology" by civilian psychologists and psychiatrists.²⁰ Eugenics was one of the dominating theories of the interwar years. This theory advanced the notions that "the possibility of improving the qualities of the human species....especially by means such as discouraging reproduction by persons having genetic defects or presumed to have inheritable undesirable traits (negative eugenics) or encouraging reproduction by persons presumed to have inheritable desirable traits (positive eugenics)." ²¹ Simply stated, the military came to believe that individuals susceptible to combat stress could be identified through screening and excluded from military service. The majority of individuals considered to fit into this criterion were blacks, Jews, and southern Europeans.²² This period marked a regression in the military's attempt to understand and deal with combat stress. The emerging mindset was individuals most likely to become stress casualties could be excluded from military service, thereby reducing the costs to the military and the loss of combat effective soldiers during combat.

World War II

"The [US] military and the nation went into World War II believing almost implicitly that soldier selection [screening] would be the solution to [eliminating] all military health problems."²³ Over one and a half million men were rejected and excluded from joining the military for emotional, mental, or educational deficiencies. "Between 1942 and 1945 over

²⁰ Ibid., 43.

²¹ Ibid., 44.

²² Ibid., 44.

500,000 more [soldiers] were separated from the Army on psychiatric or behavioral grounds.”²⁴

The screening program’s effectiveness was tested early in the war. Many U.S. service members that fought at Guadalcanal became combat stress casualties. Likewise, U.S. forces that fought in North Africa witnessed a high combat stress casualty rate. The pre-selection process to exclude weak and susceptible individuals was seemingly a failure. The military was again in a reactive posture.

The term combat exhaustion became the newest label for combat stress during WW II. It replaced the terms war neurosis and psychoneurosis because negative connotations were associated with the terms. This change in terminology made it easier for the medical corps to provide treatment. Again, the initial loss of service members as combat stress casualties significantly impacted the ability of units to accomplish the mission which necessitated the need to diagnose and treat soldiers suffering from combat exhaustion. In a medical study conducted by a General Board it concluded that “combat exhaustion was one of the major causes of non-effectiveness among combat troops” and “combat exhaustion ispreventable and emphasis should be placed on prevention rather than on treatment.”²⁵ It was recommended by this board “that the term combat exhaustion, forward of the Army’s rear boundaries be continued” because this was an effective means of treating and returning to duty combat troops that suffered from exhaustion.²⁶

World War II witnessed both unsuccessful attempts and successful strides within the military, especially the medical corps, in dealing with and minimizing the effects of combat exhaustion on service members. In the General Board report it was recommended that “all

²³ Marlowe, 47.

²⁴ Eli Ginzberg. *The Lost Divisions*. New York: Columbia University Press, 1959.

²⁵ L.H. Ginn, W.E. Wilkinson, and Edward J. Whitely. *Combat Exhaustion*. United States Forces, European Theater: General Board, 1945, 11.

²⁶ Ibid., 12.

echelons of the medical service must be combat exhaustion conscious” and “young, general duty, medical corps officers should be given special training in practical neuropsychiatry with special emphasis on combat exhaustion and neuropsychiatry reaction in war.”²⁷ Several effective methods were identified by the medical corps for the prevention of combat exhaustion. They included “the application of good leadership, the maintenance of unit spirit and spirit de corps, periodic relief of front-line troops for rest and rehabilitation, rotation of individuals from combat units to assignments in rear areas, indoctrination and training of replacements and their assimilation into the unit prior to entry into combat, the maintenance of a high state of discipline, and screening for the purpose of eliminating those individuals with mental and physical defects.”²⁸

The U.S. military was ultimately successful in treating combat stress casualties. But, it had to re-learn the lessons of WWI because of the failure of the screening process. The North African Campaign, the assault landings on the beaches, and the Marines amphibious assaults in the Pacific all produced many combat exhaustion casualties. World War II featured battles that exposed soldiers to high levels of stress for extended periods of time with little to no opportunity to rest. An American psychiatrist, Thomas Salmon, was sent to the theater of operations to evaluate the situation and make recommendations on how to prevent combat stress casualties. His observations formed the foundation of preventive measures that should be taken to prevent the loss of combat fighting forces due to combat stress. The adjustment he recommended was the allocation of a psychiatrist to all U.S. divisions. The changes once made allowed the military to assume a proactive posture in dealing with the impact of combat stress on soldiers. However, at the conclusion of WW II, the focus of training and education to understand and treat combat stress remained on the military’s medical corps.

²⁷ Ibid., page 12.

²⁸ Ibid., 11.

Korean War

The Korean War again found the Army in a reactive posture. Initially, combat stress casualties were high (250 per thousand per year).²⁹ The Army sent COL Glass to Korea to establish forward psychiatric care. He instituted the three-echelon system of care to treat combat stress casualties. The first echelon was the division psychiatrist, second echelon theater-level hospitals, and the third echelon Japan- or U.S. based hospitals. Dr. Glass created mobile mental health units which helped reinforce the division psychiatrist during periods of heavy fighting.³⁰ Combat stress casualties rates decreased and return to duty rates (RTD) increased. The high level of stress produced by intense fighting and heightened reactions was not as prevalent. Combat tours were shorter in duration which meant service members could return to some sense of normalcy quicker.

The Korean War, like previous wars found the military reactive in its attempt to minimize the effects of combat stress on combat effectiveness. It took work by military medical professionals to change the tide. This war witnessed the change in the organization of care for stress casualties. Once the changes were instituted the Army reached a positive posture, and the focus shifted to prevention.

Vietnam War

The Vietnam War was very different from the previous wars because of the low proportion of combat stress casualties produced during the war. However, a massive number of combat stress casualties came years later. The term PTSD was introduced because of this war. Vietnam broke from past patterns of combat stress casualty production. The combat stress casualties were at their lowest for the years with the most intense fighting. This conflict also

²⁹ Todd C. Helmus and Russell W. Glen. *Steeling the Mind: Combat Stress Reaction and Their Implications for Urban Warfare*. Santa Monica: RAND, 16.

provides an excellent example of the importance of having a preventive program that starts prior to deployment and continues through to post-deployment.

The Vietnam Conflict fell into three very distinct phases, each was marked by differing perceptions of the war, its nature, its legitimacy, and the way combat was executed. This war also intersected with the drug epidemic that was prevalent in U.S. society at the time. The first phase spanned from the advisory phase to the insurgency fight. It extended from the 1950s through mid-1965. The second phase spanned from mid-1965 to the Tet Offensive and was a combination of counter-insurgency and conventional fighting. Phase three spanned from the defeat of the insurgency after Tet to the final withdrawal of U.S. service members. Conventional warfare characterized the fighting during this phase. The change in phases is important because it required a mindset change in Soldiers as to the execution of combat.

The Vietnam War did not have the traditional fronts and clearly delineated battlefield geometry because soldiers operated in a jungle environment where the enemy was all around. This ambiguity increased the stress of soldiers operating in this environment because of the fluidity of the battlefield. Hard fighting by soldiers was typically followed by periods of rest and decompression. “Air superiority, brevity of contacts with the enemy, rapid medical evacuation for all casualties, and twelve month tours combined to reduce the stress, fear and fatigue levels compared to other wars.³¹

The Vietnam War demonstrated the importance between perception and reality. The media’s portrayal of the war produced a belief in the minds of our population that the U.S. was losing the war. However, soldiers were left confused by how Americans could say we lost the war, when they never lost a battle. Tactical victories by our military did not translate into strategic success for our country. Service members returning from this war had no outlet to release the pent

³⁰ Ibid., 17.

³¹ Brian H. Chermol, “Psychiatric Casualties in Combat,” Military Review, LXII (July, 1983), 27.

up frustrations that had gathered because of the country's perception of their performance and presence in Vietnam.

The re-deployment home was a source of stress for soldiers who typically re-deployed from the conflict alone or in small groups. They did not return home to hangars filled with family members, friends, and fellow soldiers. Because of the public perception of the war these soldiers were not viewed as war time heroes and welcomed home. They were often insulted and disrespected because the war was viewed as wrong. The end result was service members became long-term combat stress casualties. More than any previous conflict this war highlighted the importance of using a three-phased approach: Pre-combat training and education, combat decompression, and post-deployment care³².

Desert Shield/Storm

The Gulf War was a conundrum. The one hundred hour war which witnessed the defeat of Saddam Hussein's military forces at the hands of a U.S. led coalition was spectacular. However, the number of long-term combat stress casualties produced makes it a mystery. This conflict featured our air superiority and limited direct contact between coalition and enemy forces. Our weapons systems gave us the ability to engage and destroy enemy forces at long distances. In order to understand why the casualties were so high this conflict has to be viewed through its two operations: Desert Shield and Desert Storm.³³

Desert Shield/Storm encompassed pre deployment to pre-command of major combat operations. The deployment to the Middle East was a consistent stressor on many service members. Service members experienced stresses for several reasons. First, there were several false starts. Soldiers were alerted to deploy and said their goodbyes to family and friends only to

³² Marlowe, 113.

³³ Ibid., 115.

find out the departure was postponed. Second, there was ambiguity because soldiers did not know how long the deployment would last. During the prehostilities soldiers also experienced stress related to concerns about family and friends. A soldiers' ability to call home on a frequent and consistent basis was limited. The delivery of mail was extremely slow. These factors produced stress because the soldier did not know what was happening back home. This conflict marked the first time that the majority, sixty percent, of the deploying force was married.³⁴ Finally, soldiers did not know when the ground war would commence or how long it would last. Therefore, the stresses produced by the deployment outweighed the stresses of combat for many of the service members.

The living conditions and lack of recreation was a stress producer. Soldiers were isolated from the host nation populace and they had no place to go or escape for quiet time. Soldiers and leaders shared living space which led to a perception of constant observation and evaluation. The living quarters were very basic. Tents and cots were the norm; however, some Soldiers had to sleep in their vehicles, on the ground or in holes next to their vehicles because tents and cots were unavailable. There was the problem of crowding because of limited space. MWR (morale, welfare, recreation) equipment was in short supply. This prevented Soldiers from having outlets through sports activities and games to relieve their stress.

Enemy forces and the perceived threat created stress. Iraq's military was the fourth largest in the world. Its weapons and equipment were supplied by the Russian and thought to be comparable to U.S. weapons and equipment. Iraq was known to posses chemical weapons and Saddam Hussein had previously used these weapons against Iran. The Iraqi military was thought to be battle hardened and tested because of its eight year war with Iran. Service members were

³⁴ Marlowe, 124.

concerned about a potential terrorist attack or Scud missile carrying chemical or biological agents getting through. All these factors produced stress on service members.³⁵

Combat stress teams were deployed to the brigade/battalion level and treatment was swift and effective. The number of casualties during the conflict was low; however, large numbers of combat stress casualties emerged after the conflict was over.

The re-deployment home was better than those from the Vietnam War, but stress was still felt. Soldiers returned home as victors and heroes. They returned home with their units and hangars filled with family and friends. The public perception and support for Soldiers was positive. Yet, doubts about continued service became another source of stress. Many service members did not know if they would continue to serve in the military because of the down-sizing of the force. This created stress because of employment and financial uncertainty.

This historical look at the military and the ways it has addressed combat stress demonstrates the evolution of terms, the incorporation of medical personnel at the lowest levels, and the creation of stress control teams in an attempt to minimize the negative effects. More importantly, it demonstrates the reactive nature the military has had at the beginning of each war or conflict. It took significant measures to stem the impact of combat stress and change the posture of the military into an active and positive position. Each war had different conditions, societal differences, technological differences, and medical differences. Irrespective of these differences, the posture of the military throughout has been reactive and it has usually taken drastic measures to curve the impact of combat stress. As one looks at these historical examples a few things stand out. First, the duration of wars has typically decreased, Vietnam being the exception. Direct U.S. involvement in World War II lasted from 1941-1945, the Korean War: 1950- 1953 (armistice signed, the war is not officially over), Vietnam War: 1963-1973, Gulf War: 1990-1991. The length of wars and conflicts has changed because of the change in our society's

³⁵ Ibid., 123-128.

tolerance for war. This can be attributed to several factors that include technological advances, medical advances, change in the will of the people, ability to mobilize for warfare, and societal values to name a few. Secondly, warfare has become increasingly distant. WW I was marked by trench warfare, WW II was marked by a mobile battlefield, the Vietnam War was marked by close air support and helicopters, and the Gulf War was marked by weapons systems that could travel over long distance to engage the enemy. Warfare is not as personal in many instances on today's battlefield. Thirdly, the focus of combat stress has resided primarily with the civilian and military medical arenas, as well as, the academic world as opposed to those mostly affected by these stresses; the soldiers, airmen, sailors, and marines. From World War I through the Gulf War the focus has been on how the military medical profession can do a better job identifying, understanding, and treating those that suffer from combat stress in order to return them to duty. We see the work of civilian psychiatry in forming the basis of knowledge in WWI, the use of divisional psychiatric teams during WW II, the creation of tiered treatment levels, and the creation of combat stress teams deployed to lower echelon units during Desert Shield/Storm. Finally, this historical analysis demonstrates the lack of education for service members and leaders about combat stress prior to the execution of combat operations, the importance of mitigation during war, and treatment post-deployment.

Doctrinal Evolution

This section will analyze Army doctrine for combat stress. Counter-insurgency doctrine is included for illustrative purposes because of parallels between COIN and Combat Stress doctrine. It will trace this doctrine from the 1980s to present-day. It will identify two types of operations that service members conduct because they are a key component when determining the impact of combat stress exposure. The level of importance given to combat stress within each field manual, the primary focus of each manual, and the target audience will also be explored.

The U.S. military has been reactive when dealing with conducting counter-insurgency warfare. Warfare after WW II was repeatedly marked by the use of irregular warfare. Mao's insurgency in China, Castro's insurgency in Cuba, the Venezuelan insurgency, and the Guatemalan insurgency are a few examples; yet, our armed forces ignored this fact and tried to fight an unconventional war using conventional tactics in Vietnam.

A counter-insurgency manual was written and used throughout the 1980s; however, in the 1990s this manual and doctrine was relegated to a minor role because the war and conflicts of this decade were almost exclusively conventional and low-intensity in nature. Desert Shield/Storm was a conventional fight that witnessed our quick defeat of the enemy and the avoidance of another Vietnam. This conflict reinforced our military's belief that our military doctrine, Air-land Battle, was correct. Counter-insurgency doctrine was relegated to obscurity in terms of both military training and education.

US military doctrine for counter-insurgency warfare was out-dated when we began OIF

1. US military training at the NTC focused primarily on the conventional fight, while JRTC focused on counter-insurgency training to a degree. Operation Iraqi Freedom began as a conventional war in which we proved the superiority of US forces to execute and win a conventional fight. As the war transitioned from a conventional to an un-conventional fight, the military was unprepared doctrinally. The new counter-insurgency manual released in December 2006 came more than three years after the insurgency started, and more than twenty-five years after the original manual.³⁶ This discussion about counter-insurgency warfare and the U.S. military illustrates the reactive posture our military assumed because of out-dated doctrine and lack of military training and education. This is the same posture we find ourselves in presently concerning the impact of combat and operational stress.

³⁶ Danielle Giovannelli, ed. "Army Releases new counterinsurgency field manual." NCO Update, Volume 16 No.1, 1st Quarter 2007, 2

An examination of military doctrine on combat stress reveals that a set of guidelines has typically been published at the conclusion of wars or conflicts. Additionally, looking at the study of combat stress from a historical perspective the educational focus has trended towards civilian and military medical professionals, and the military's chaplaincy. While this group forms the bedrock for evaluating and treating combat stress, education of Soldiers and leaders has proven insufficient. A field manual (FM) with combat stress as the central theme, FM 6-22.5, was published in June 2000 after US involvement in various types of military operations throughout the preceding decade. The Marine Corps predecessor to FM 6-22.5, Fleet Marine Force Manual 4-55: *Combat Stress*, was released in April 1992 after the Gulf War. The Army predecessor to FM 6-22.5, FM 22-9, was released in December 1991. The original version of FM 22-9: *Soldiers Performance in Continuous Operations* was created in December 1983. It was produced because of efforts undertaken by military leadership during the early 1980s to re-vamp the Army that emerged from Vietnam through the creation and revision of doctrine. Another motivating factor for the creation of the 1983 manual was the Israeli invasion of Lebanon.

Army Doctrine

An analysis of the evolution of Army doctrine for combat stress demonstrates the reactive nature of this doctrine. The study of combat stress began during World War I; however, almost seventy years elapsed between the first cases of combat stress to the publication of doctrine for those affected by these stresses.

The early '80s marked a period in our military history where our doctrine was revamped, updated, and in some cases created in order to lay the foundation for the new Air-Land Battle our military would use to fight future conflicts. The enemy was identified as members of the Warsaw Pact and it was assumed that the next major conflict would be a conventional fight. In an attempt to prepare soldiers for future conflicts, the Army published its first official doctrine, Field Manual 22-9: *Soldier Performance in Continuous Operations*, that addressed combat stress in December

1983. Leaders were the primary audience of this first manual. Continuous and sustained operations formed the basis for our initial combat stress doctrine. Continuous operation (CONOPS) was not very well defined in this first manual. It was described in these terms, “Continuous land combat is an advanced warfare concept made possible by almost complete mechanization of land combat forces and by the technology that permits effective movement at night....Combat can and will continue around the clock at the same level of high intensity for extended periods.”³⁷ It also stated soldiers may have the chance to sleep but it may be brief and/or fragmented. Sustained operation (SUSOPS) was defined in these terms “the same soldiers and small units engage in continuous operations with no opportunity for the unit to stand down and very little opportunity for soldiers to catch more than a few minutes of sleep.”³⁸ These definitions were ambiguous at best.

The primary focus of this manual was not on combat stress; instead it was on how to conduct continuous and sustained operations. This manual discussed the effects of CONOPS and SUSOPS, degradation caused by these operations, the importance of sleep, and how to develop sleep routines. It went on to give methods to counter degradation that result from sleep loss and CONOPS. Information on combat stress was dispersed through-out the manual. It addressed operations that would induce stress and create degradation; however, it did not focus on combat stress. It focused on the types of operations that induce stress.

This manual did have some positive aspects that formed a solid basis for dealing with combat stress. The Army recognized the important role leaders must play in order to effectively deal with combat stress. After action critiques, physical fitness, tough training, competition, cohesion, spirit, morale, commitment, and resource management were a few of the means

³⁷ U.S. Department of the Army, FM 22-9: *Soldiers Performance in Continuous Operations*. Washington, D.C.: Government Printing Office, December 1983, 1-2.

³⁸ Ibid., 1-2.

introduced as ways to deal with increased stress. The manual included development of coping skills to counter the effects of stress. It named and described coping techniques such as relaxation techniques, self-suggestion, meditation, and inoculation as ways to minimize the effects of combat stress. This was one of the best contributions made by this introductory manual. It gave tangible ways to cope with stress. However, this manual proved inadequate because it did not address combat stress as the root cause of stress casualties. Combat stress was relegated to a trivial position while operations the Army expected to perform received the bulk of attention in this first manual. Arguably, a large reason for this focus was the Army's desire to reform itself after the perceived loss in Vietnam and the desire to avoid a potential loss to Soviet forces in combat.

The successive FM 22-9 was published in December 1991, but it did not do much better than its predecessor. CONOPS was better defined in the new manual and the target audience was unit leaders. The purpose was "to help leaders identify, counter, and minimize the degrading effects of fatigue and stress."³⁹ Again, combat stress was relegated to small role within the manual. The primary focus of the manual remained on how to conduct continuous operations and functional sleep degradation. The final chapter of this manual was dedicated to stress in CONOPS.

The updated manual had some good parts. It provided clear examples of sleep management and the link between sleep and performance. Means of countering sleep degradation were expanded to include safety, food intake, fluid intake, and equipment load.⁴⁰ The leader's role was emphasized again. The new manual included an appendix which was a commander's guide for stress in battle and relaxation and stress management techniques had their own appendix. Perhaps the best contribution to this update was the addition of the combat stress

³⁹ FM 22-9, dated December 1991, Preface.

⁴⁰ Ibid., 4-2 to 4-6.

reaction management principles: Proximity, Immediacy, Expectancy, and Simplicity (PIES).⁴¹

The first three principles of this concept were first used during WW II and were published by Kenneth L. Artiss in 1963.⁴² MAJ Flora re-introduced these first three principles in his thesis written on understanding battlefield stress causes and counter-measures in 1987.⁴³ However, there was a significant gap between the creation of these principles and their publication in Army doctrine. This was yet another indicator of the reactive nature of our doctrine.

December 2000 marked a change in Army doctrine as the new manual for combat stress became FM 6-22.5 and combat stress was no longer treated as a subset of CONOPS. The new manual was titled “Combat Stress” and CONOPS and SUSOPS were now the subsets. The new manual stated that for continuous operations careful planning and resource allocation is required to allow for a minimal amount of sleep. Concerning sustained operations, the manual only mentioned that the opportunity to get the minimal amount of sleep needed to conduct continuous operations will be non-existent. The sustained operations definition does not stress the importance of standing down a unit that has been involved in SUSOPS. This manual did mark collaboration between the Army, Navy, and Marine Corps to share doctrine on such an important subject. This manual included examples of mild and severe stress reactions that could be used to identify an individual suffering from combat stress. It also included a chapter on combat stress prevention, management, and control and the role of the leaders and leadership was emphasized. This was the first manual that addressed the need for an effective combat stress control program. The program had three phases; Pre-deployment, Deployment and Combat, and Post-Combat. Chapter Three provided a list of Command Leadership Actions for individuals that become combat stress casualties. It talked about a graduated response to care and the need for leaders to know what

⁴¹ Ibid., 5-8.

⁴² Kenneth L. Artiss, “Human Behavior Under stress: From Combat to Social Psychiatry,” *Military Medicine*, Volume 128 (1963), 1011-1015.

combat stress looked like. The combat stress casualty intervention concept changed from PIES to BICEPS.⁴⁴ This concept was Brevity, Immediacy, Centrality (Marines)/Contact (Army), Expectancy, and Simplicity. It acknowledged that combat stress reactions are inevitable, but high casualty rates are not. Chapter Four dealt with sleep deprivation, CONOPS, and SUSOPS and ways to counter its effects.

The latest doctrinal installment which is still in draft form marks another evolution in the military's thinking about combat stress. The Army has expanded its view of combat stress to recognize that operational stress is just as destructive. The field manual released in December 2006 is FM 6-22.5, *A Leader's Guide for Combat and Operational Stress (Small Unit)*. The newest Army term is Combat and Operational Stress (COS). This label acknowledges that "the effects of COS are experienced by all Soldiers spanning all phases of military operations in both peace and war."⁴⁵ This new term recognizes that stress impacts a service member psychologically, emotionally, and physically not only when in a combat zone, but, also when conducting training exercises or stability and reconstruction operations. Suicide awareness and the impact of COS on family members are included in this new manual. The Effective Combat and Operational Stress Control Program have expanded to four phases: Garrison Activities, Pre-Deployment, Deployment and Combat, and Post-Combat.⁴⁶

This new manual marks the first steps in the right direction toward the military assuming a proactive posture to deal with COS. It has continued and broken with tradition at the same time. It has continued the tradition of the Army making in-progress strides to address the impact of combat stress. It has broken from tradition because it has not waited for the conclusion of the

⁴³ Flora.

⁴⁴ FM 6-22.5, Glossary-3.

⁴⁵ Ibid., 1-3.

⁴⁶ Ibid., 3-2 to 3-7

war/conflict before updating doctrine. Both of these are positives; however, work remains if the Army and the military will truly assume a proactive posture.

Operation Iraqi Freedom (OIF) 1

The Iraqi War has some similarities to past wars/conflicts. Like the Vietnam War, this war has distinct phases; service members have conducted multiple deployments; and set tour lengths have been used. This war, like all the previous wars and conflicts, began with the military in a reactive posture concerning combat stress control. Finally, OIF has the potential to produce many long-term casualties long after the war is over just as the two previous conflicts, the Vietnam War and Gulf War. An unidentified U.S. battalion will be used to illustrate the dangers of introducing avoidable stressors and the importance of educating soldiers and leaders about combat stress before they enter a combat zone.⁴⁷ This section will look primarily at the first phase of OIF. This section will not talk about present-day events. However, there are some lessons to be learned and captured from this short but still relevant period.

The phases of OIF can be broken down into pre-deployment and Major Combat Operations, the insurgency/counterinsurgency, and the 2007 surge. The first phase started with the first units preparing to deploy to Kuwait and ended on May 1, 2003. The second phase started at the conclusion of major combat operations in May 2003, and continued to December 2006. This phase encompassed the insurgency/counter-insurgency fight. The next phase started with the surge and will continue until we reach pre-surge strength. The final phase may be the redeployment of a majority of military forces from the country. These different phases are important because they required a change in mindset by service members; the rules of engagement changed; and service members had to perform different/non-traditional roles. These different phases also correlate to the changing level of acceptance of the war by the American

⁴⁷ This is not a hypothetical unit. The scenario is an account of actual occurrences.

public. Initial public support was high, but as the war has continued, support has waned.

However, support for our service members has not waned and this is of vital importance.

This war has featured the conduct of multiple deployments by service members. These deployments have denied service members' the opportunity to rest and decompress from the rigors of the previous deployment (s), personally re-fit, and reset their family life. This has increased the strain on families and marriages. It has also created the condition where combat stress is accumulating on service members because they have not properly decompressed. Some individuals move from one unit that recently deployed to another unit which is preparing to deploy.

Tour lengths have varied in this war. Initial tour lengths were set for twelve month rotations; however, as the nature of this war changed from conventional to un-conventional so did rotation lengths. The increase in tour lengths from twelve to fifteen months was a significant stressor for both service members and their families. It was significant because the expected return home was delayed. It also increased COS because service members knew they would be in harms way for an additional amount of time. This has also increased the strain on the military as a whole

Operation Iraqi Freedom has again found the U.S. military in a reactive posture. Military doctrine was published. However, at least initially it was not followed. Dr. Marlowe stated in an interview for RAND that "Field manuals are good, but many people never read them."⁴⁸ Briefings about combat stress and its effects were rarely addressed prior to units deploying to combat. In many units the stress coping skills techniques and briefings on combat stress for deploying soldiers was not conducted. The emphasis was on conducting tough and realistic training, conducting physical fitness training, and preparation for the deployment.

⁴⁸ Helmus and Glenn, 124.

Like the two previous conflicts the present-day conflict has the potential to produce many long-term stress casualties after the war has ended. Because of the multiple deployments and tour lengths the amount of COS experienced by troops has been cumulative. The military's reactive nature could also lead to future high rates of long-term combat casualties. Maladaptive stress reactions have begun to surface more and the suicide rate among service members is at highest point as compared to recent times because of this reactive posture.⁴⁹ Marital discord and divorce rates have also increased. Misconduct stress behaviors have surfaced with incidents such as the Abu Ghraib and continue today both in the combat zone and at home.

FM 6-22.5, dated 2000, stated some pre-deployment stressors facing service members include long working hours, preparation for training, fear of the future, family worries, and anxiety about unit readiness.⁵⁰ The ways to acclimate service members to operate in stressful environments and operations included physical fitness training, stress coping skills training, sleep discipline, task allocation and management. An example of stressors that were induced by the pending deployment and leaders who did not understand the effects of stressors can be seen in the conduct of an unnamed unit preparing to deploy. The following is an account of what happened to a unit preparing to deploy in support of Operation Iraqi Freedom I.

"The unit was notified of a pending deployment in support of Operation Iraqi Freedom in mid-January. Approximately, twenty-four hours prior to notification this unit deployed a platoon along with the company first sergeant to participate in a small unit exchange. Steps by the company commander and battalion operations officer were taken immediately to recall the platoon; however, the request was denied. The company continued to conduct the small unit exchange as if it was business as usual. The company conducted this exchange and prepared the remainder of the company for deployment simultaneously. When the deployed platoon returned they were behind in equipment draw, equipment packing, and conduct of other pre-deployment requirements. This situation added additional stressors to the personnel of the company. The battalion did not conduct any briefings on combat stress or stress coping techniques training. The

⁴⁹"Army suicides up 20 percent in 2007," CNN.com\health January 31, 2008.
<http://www.cnn.com/2008/HEALTH/01/31/army.suicides.ap/index.html>

⁵⁰ FM 6-22.5, 2-14 to 2-15.

focus remained on conducting physical fitness and other combat preparation training. The battalion also received an influx of new Soldiers in order to get up to the required percentage of individuals needed to be at full strength.”⁵¹

The above situation was unique in some instances. However, some of the things that occurred are probably applicable across the board to units that were preparing to deploy in support of OIF I on a short timeline. The failure to educate service members on the existence and effects of combat stress was one of them. This was the equivalent of someone driving down the street and being blind-sided by another vehicle. The shock from impact was hard, sudden, and unexpected. Instead of bracing and preparing for the shock some individuals were left exposed. Briefings on combat stress for the individuals (junior leaders and soldiers) most likely to be affected were not conducted by many units prior to entering the war. This example demonstrates the importance of minimizing stressors during pre-deployment and educating service members on combat stress prior to deployment.

The next part of the process was deployment and final preparation for combat. FM 6-22.5 talks about the way soldiers get into theater (deployment vehicle), information flow, family support, religious support, physical and recreational activities, and integration of new members into the unit. It is important to pre-plan actions that need to occur when deploying and the impact on units. A key area is allowing service members to adjust their internal clock when deploying to a new country and operating in a new time zone. Again using the unidentified unit to illustrate how a plan that fails to address COS prevention.

The unit deployed on Valentine’s Day instead of deploying prior to or after this day. In retrospect, family members commented that if Soldiers from the unit had been killed, they would have always associated this holiday with the last time they saw their loved one alive. This unit deployed to Kuwait and hit the ground running. Soldiers and leaders did not get a chance to adjust to the new environment and time zone. This unit arrived in country in the middle of the night and a few hours later the leaders were on a recon of the training areas in Kuwait. Within forty-eight hours the entire battalion was training and this training lasted for about two and a half weeks without a break. Because soldiers

⁵¹ Interview conducted with a anonymous service member deployed to Kuwait in February 2003.

did not have to go home after work the training was conducted for extended periods of time. Part of this was an attempt to train and integrate the new soldiers and teams that were added to the task organization before the deployment.

Another part was poor planning. This tempo required careful attention because of the potentially negative effects on the unit. Ultimately, the chaplain had to make a strong recommendation to the commander to allow the soldiers to have some down time because they needed a break.⁵²

The above example illustrates the importance of allowing individuals to acclimate and not inducing too many stressors before a unit enters the combat zone. Additionally, consideration of the impact on family members should at least be addressed even though it may not change the deployment plan.

The final part was conduct of conventional combat operations. The U.S. military displayed its superiority both technologically and tactically in the conduct of conventional operations. However, some units conducted continuous and sustained operations over extended periods of time during the early stages of the war. This increased the degradation and decreased the combat effectiveness of individuals and units. The need to allow these units to properly decompress and re-fit after CONOPS and SUSOPS was paramount. However, leaders' lack of awareness to the impact of these types of operations prevented them from taking the proper steps to mitigate its effects.

Service members' re-deployments home from OIF I has been positive in nature and execution. The American public supports the troops that have served in Iraq. Service members re-deployed with their units to the sounds of the band and cheers from family, friends, and peers. This was positive; however, the adverse affects of combat stress have begun to surface.

At this point the Army has turned its focus to identifying soldiers that suffer from PTSD while ignoring the root cause of this condition, combat and operational stress. The military is busy trying to identify those who may suffer from the long-term outcome of combat stress;

⁵² Ibid.

however, the need exists to turn the attention to the precursor of short and long-term effects. The military's medical profession has played an important role in dealing with combat stress, but, it is paramount that military leaders at all levels recognize the active role they must play in order to mitigate the devastating effects of COS.

BATTLEMIND

This section will provide a brief overview of a concept created by Walter Reed Army Institute of Research (WRAIR) designed to help units, leaders, individuals, and families understand what combat and operational stress is and how to deal with it. This concept offers a chance to transition the focus to prevention. However, the challenge remains in implementation. FM 6-22.5 dated December 2006 mentions BATTLEMIND, and the Army has a website dedicated to this concept.

BATTLEMIND is designed to prepare soldiers, leaders, and families to deal with combat stress during pre-deployment, deployment, and post-deployment from combat and operational missions. Its purpose is defined as “A Soldier’s inner strength to face fear and adversity during combat, with courage. It is the will to persevere and win. It is resilience.”⁵³ Figure 4-1 lists what the acronym stands for. This concept is designed to educate leaders, soldiers, and family members about what to expect in combat; the nature of combat; the nature of deployments; how to steel your mind; how to be a battle buddy; and what leaders and soldiers should know and do to prepare to deal with combat and operational stress. This concept represents an attempt to change the negative stigma that has developed over the years for combat stress casualties. It offers a potential means for the military to become proactive in its battle against COS and its negative consequences.

⁵³ Walter Reed Army Institute of Research, BATTLEMIND Training Preparing for War: What Soldiers Should Know and Do Pre-Deployment, Slide 2.

BATTLEMIND focuses on leaders because it realizes that the effectiveness of any program will require active leader support. Figure 4-2 lists ten unpleasant facts about combat, the associated findings, and what actions leaders can take to change them. Ten corresponding concepts emerge from these facts and leader actions that help to deal with the realities of combat stress. BATTLEMIND focuses on soldiers because they are our most precious resource. Without soldiers the Army would fail to exist. It takes combat-effective soldiers to operate the weapons systems, drive the vehicles, and form the team. BATTLEMIND goes a step further and addresses family members because of the realization that combat stress affects more than just the soldier. The multiple deployments that soldiers make affect the family just as much. The increased marital discord and divorce rate among service members that have deployed is one indicator of this fact. Soldiers and family members must recognize the changes that occur when a service member deploys. The spouse assumes duties normally performed by the deployed Soldier. If children are involved this presents another variable that must be addressed. BATTLEMIND seeks to help service members make the transition back into their family life.

BATTLEMIND has received mixed reviews from various groups and individuals. VA Watchdog dot org asked vets diagnosed with PTSD several questions: “Can pre-deployment intervention and post deployment counseling really prevent PTSD? Did you find it [BATTLEMIND website] useful? Do you think this kind of intervention works? Would this type of program have helped you?”⁵⁴ The Baumholder Health Clinic has developed an effective approach to helping re-deploying soldiers based on the BATTLEMIND program.

“As part of coming home, soldiers go through a seven-day reintegration process that covers everything from personnel and finance to legal and dental matters. Emphasis ... placed on the soldiers’ mental health after deployment... We’re seeing soldiers at all levels being much more open and forthcoming about how they really are doing in terms of mental health, rather than feeling they need to hide it or not talk about this. Special awareness is being paid to soldiers and units

⁵⁴ Larry Scott, “PTSD VETS REACT TO BATTLEMIND”, January 4, 2008. VA Watchdog dot Org. Accessed through www.vawatchdog.org.

that were exposed to the most trauma... Reintegrating soldiers fill out a questionnaire with pointed questions about mental health, focusing on depression and post-traumatic stress disorder. If the soldiers answers the mental health question a certain way, they sit down with a social worker for a screening to determine if they need follow-up care...Soldiers go through a Battlemind briefing as part of their reintegration process.”⁵⁵

One soldier stated that her unit lumped the BATTLEMIND briefing together into a pile with other briefings, and it was basically a check the block briefing instead of one that received emphasis because of the subject. One veteran with PTSD stated his belief that this program is an unrealistic attempt by the DOD to provide lectures on combat stress and give an excuse for the VA to deny future claims because BATTLEMIND training was made available. Another PTSD veteran expressed his skepticism about the effectiveness of this program because he believes the information is too generic and does not benefit soldiers. A third veteran, also a victim of PTSD, stated,

“Ignorance was my greatest hurdle... They [the military] are at least on the right track. No doubt there will be substantial changes in the program ...over the coming years, but they are trying to do something positive. A pre/post deployment education/counseling program may or may not directly [prevent] a person from acquiring PTSD...., but I believe that properly informed troops would be able to recognize the symptoms in themselves and others and take the early action thus preventing it from becoming worse. All in all I think ‘Battlemind’ is a good and much needed start in the right direction.”⁵⁶

BATTLEMIND represents a potential means that will facilitate the Army’s transition to a proactive posture in order to mitigate the adverse effects of combat and operational stress. By recognizing the need to educate leaders, soldiers, and families before deployment, as well as, transition for these groups during post-deployment, this concept offers different ways to minimize the negative effects of combat and operational stress. This is an excellent concept in theory; however, the challenge rests in implementation because leaders must find a way to implement it

⁵⁵ Steve Mraz, “Mental Health Needs Take the Battle Beyond the War Zone,” November 9, 2006. Stars and Stripes article accessed through www.vawatchdog.org.

⁵⁶ Scott., 2.

in a positive and beneficial manner versus mandatory, check the block training. Only time will tell the utility of this concept.

Figure 4-1: BATTLEMIND⁵⁷

BATTLEMIND
Buddies (cohesion) vs. Withdrawal
Accountability vs. controlling
Targeted Aggression vs. Inappropriate Aggression
Tactical Awareness vs. Hyper-vigilance
Lethally Armed vs. “Locked and Loaded” at home
Emotional Control vs. Anger/Detachment
Mission Operational Security (OPSEC) vs. Secretiveness
Individual Responsibility vs. Guilt
Non-Defensive (combat) Driving vs. Aggressive Driving
Discipline and Ordering vs. Conflict

⁵⁷ Ibid., Slide 3.

Figure 4-2: Ten Unpleasant Facts and Associated Concepts for Leaders⁵⁸

UNPLEASANT FACT	BATTLEFIELD CONCEPT
1. Fear in combat is common	1. Even heroes feel fear
2. Unit members will be injured and killed.	2. Every Soldier is entitled to go into combat with the best chance of survival that his or her leader can provide.
3. There will be communication and information breakdown.	3. Effective communication is the responsibility of the leader.
4. Soldiers frequently perceive failures in Leadership.	4. Courage and valor in combat and in all matters are the measures of Soldier and leader performance, never personal gain.
5. Combat impacts every Soldier mentally and emotionally.	5. Combat stress reactions should be viewed as combat injuries.
6. Combat often leads to lasting adverse mental health effects.	6. It takes courage to ask for mental health support.
7. Soldiers are afraid to admit they have a mental health problem.	7. Admitting to a mental health problem is not a character flaw.
8. Deployments place a tremendous strain on families.	8. “When a Soldier is at war, his or her mind should be at peace.”
9. The combat environment is harsh and demanding.	9. Recognize the limits of your Soldiers’ fortitude.
10. Combat poses moral and ethical challenges.	10. Every Soldier needs to come home with a story that he or she can live with.

⁵⁸ Ibid, Slides 4-33.

Recommendations

A systematic program, which incorporates education, training, and phased prevention if properly integrated, will allow the military to minimize the negative effects of combat and operational stress. The training conducted by the military tends to be effective because it is tough, realistic, and replicates stressful environments. This area needs minor improvement. However, in the areas of education and a preventative program room for dramatic improvement exists. The U.S. military has made strides in its understanding of the effects of stress on service members located in combat zones, whether they actually engage in fighting or not. This progress can be seen in the use of the present-day term combat and operational stress. This term is more encompassing and accurate in its characterization and comprehension of what causes stress.

The Twenty-First Century battlefield requires unit's to conduct of full spectrum operations within the same battlespace. Here the need to understand and mitigate the effects of COS is magnified because of the different mindsets required to perform each operation. Because the U.S. military is unequalled in its capabilities it is safe to believe near-term adversaries will not engage in a conventional fight with us. Counterinsurgency warfare, operating in urban environments, and this protracted conflict are all sources of COS. Combat Stress Teams are an inherent part of the task organization of a deploying task force unit. The education should be formatted and marketed towards leaders and individuals. As we modernize our military and as technology continues to improve one fact remains: our most precious resource is the individual soldier, sailor, airman, and marine.

Historically, the attention has resided in educating military medical professionals and chaplaincy on how to deal with combat and operational stress. However, the need exists to expand this education to include leaders, service members, and their families. This change can result in the military assuming a proactive role both now and in future conflicts. There are several recommendations that can potentially change the military's posture from treatment to prevention.

First, leaders must identify the risk factors of COS on service members and themselves before they deploy to conduct combat, stability and reconstruction operations, or any other military actions that are inherently stressful. This includes training service members on how to use biofeedback techniques and implementing these methods to reduce stress. Second, DoD should institute a formal education program on combat and operational stress for leaders and soldiers. Make this plan part of the Officer Education System, Non-Commissioned Officer Education System, and Initial Entry Training. Lastly, DoD should institute a formal phased prevention program that spans from pre-deployment to post-deployment.

Soldiers, sailors, marines, and airmen are our most precious resource. Without these men and women the military would cease to operate efficiently and effectively. Even as the Army transforms, it has acknowledged the fact that the soldier is the centerpiece of the Soldier-a-a-System concept in order to facilitate optimal performance. Education and training about combat and operational stress and effective stress coping techniques are essential for all service members. Realizing that the education of our service members needs to expand to include combat and operation stress is paramount to our military's success on the 21st century battlefield. An educated service member can take the necessary precautions to personally prepare for the rigors of combat and other operational missions, as well as, assist his/her buddy in an effort to guard against the adverse impact of combat and operational stress. Leaders need education on combat and operational stress because this will help inform their planning and decision-making. This helps ensure they do not inadvertently introduce stressors or exacerbate combat and operational stress reactions within individuals and leaders in their unit. Additionally, it will ensure leaders take gradual steps to help individuals suffering from COS. It is a leader responsibility for mitigating the impact of combat and operational stress on their unit and its personnel. This has been one of the missing links between transforming from a passive to an active stance in the fight to minimize the short and long-term effects of stress. Education has to expand past the medical personnel of our military medical and mental health community, and chaplains to include leaders, soldiers

sailors, airmen, and marines because these are the individuals that will have to deal with COS and COSR.

Education about combat and operational stress should be added to Officer Education System (OES), Non-Commissioned Officer Education System (NCOES), and Initial Entry Training (IET). This training should begin at the basic courses at a minimum and continue through to senior level education for officers. Non-commissioned Officers need to begin this training at their first NCO course and continue on through the Sergeants Major Academy. This will ensure leaders have the requisite knowledge to identify COS, institute effective prevention programs into their units, and know how to use available resources to counter COS. Basic instruction on COS in IET can provide a baseline understanding of how stress impacts individuals in combat/operational zones. David H. Marlowe stated,

“It is far more important to get this (COS education) in major modules in the officer and senior NCO educational systems. Field manuals are lovely, but many people never read them. And for people to retain [the information], they’ve got to know that someone gives this a reasonable high priority. And if you’ve got a module at officer and NCO courses, there is a greater recognition that this is important. And in the Army, the other responsibility is continuing education as part of the division mental health team....I think it’s a critical recommendation....It should be placed at every level of the education system to be constantly reinforced like basic on up, like the initial NCO courses on up. The question is making it a part of the tool kit, if you will, of every leader: some knowledge of what it looks like, what it does to people, what realities are, and what can be done to prevent it and treat people.⁵⁹

Effectively addressing combat and operational stress will require a formal phased prevention plan that is supported by leaders. FM 6-22.5 lists four phases; however, the first two phases can be combined. The Marine Corps has three phases Warrior Preparation, Warrior

⁵⁹ Helmus and Glenn, 124-125. From an interview with Dr. Marlowe.

Sustainment, and Warrior Return.⁶⁰ The number of phases whether three or four is immaterial, what matters is realizing the need for a program.

The first phase is Pre-Deployment and includes “all organizational and leadership activities that occur between deployment orders.”⁶¹ This phase focuses on training and education prior to entering an environment or conducting operations that increase combat and operational stress. Our military typically does a good job in the training. This training tends to be tough, realistic, hard, and challenging. Educating service members on the “why” of training and physical fitness training as it relates to combating the effects of combat and operational stress is important. It is critical to establish a functional Family Readiness Group during this phase. Stressors will increase when the deployment order is issued because of the preparation required to deploy, fears of deployment, un-resolved personal matters, etc. Briefings to service members and their families about the impending deployment should occur in order to prepare these groups and provide a forum to address any fears and concerns. The BATTLEMIND Programs has some useful briefings that may aid in this area.

The next phase is Deployment to conduct combat and/or operational missions. In this phase the command should ensure service members remained informed about the deployment, family readiness groups are functional, and planning and resource allocation are thorough in order to minimize the induction of additional combat or operational stressors. Pushing Combat Stress Teams down to units that have experienced a traumatic event and properly planning restoration periods for units involved in sustained operations are examples of ways the command can take a proactive role in minimizing the effects of COS.

The final phase is Post- Deployment. In this phase the focus is on ensuring service members return to home to a positive welcome. During this phase availability and access to care

⁶⁰ U.S. Marine Corps’ Warrior Preparation Brief, Slide 1.

⁶¹ FM 6-22.5, 3-2.

should be emphasized. Service members can conduct re-integration training, receive additional briefings on life after deployment, and go through periodic screenings to help identify anyone suffering from the effects of deployment.

There is an overlap and interdependence of training, education, and preventative program needed to effectively minimize the adverse effects of combat and operational stress. Each area is unique and distinct, but it also builds and reinforces steps taken in the other areas. It does no good to be good in two out of the three areas, in order to be effective all three areas must be implemented and receive support from leaders.

These recommendations will require a fundamental change in how our military addresses COS if we expect them to take root and change our posture towards prevention. It is time that our military breaks its cycle of entering conflicts ill-prepared to deal with combat and operational stress. The Twenty-First Century will demand this because the military will operate across the entire spectrum of operations, and our country and military can not and should not spend this century repeating the reactive patterns of the last century.

Potential Future Studies

This paper focused on minimizing the effects of combat and operational stress for active duty service members. It was by no means exhaustive and other areas still require research. These areas include: the cumulative result of multiple deployments, the impact of COS on National Guard members and Reservists; the impact of deployments on families; and how to effectively develop leaders to understand and deal with COS.

There are some individuals that are on their fourth or fifth deployment to Iraq and/or Afghanistan. Too often today an individual moves from one unit where they deployed to another unit about to deploy. A research paper that looks at the cumulative of the multiple deployments can help our military take a look at the long-term implications on individuals.

The second recommended area would look at our National Guard and Reserve units. It is an important area because National Guardsmen and Reservists upon re-deploying have a short timeframe to re-integrate into society. The potential exists for these individuals to not get properly diagnosed, as well as, receive treatment for their condition. The Army does a good job of trying to identify combat stress casualties among active duty soldiers. However, National Guard and Reservists can potentially slip through the cracks. They typically do not have access to the same level of military care active duty service members receive.

The impact of combat stress on families is another area that merits further study. The immediate family, to include children, of the service member should be the focus of the study. A couple of years ago, the wife of a commander took her life along with their children. A possible reason for this was the stress created on this spouse because the service member was going on another combat tour. Family members, spouses, and children experience an increased level of stress when their service member deploys into a dangerous environment. Attention should be paid to ensuring support and services are made available to this group.

The final recommendation addresses the need to look at how to modify and incorporate COS training within the Officer Education System (OES) and Non-Commissioned Officer Education System (NCOES). This present conflict has and continues to produce combat-tested leaders and the challenge that remains is educating our future leaders. A need exists to address how the education of these leaders can improve to account for the experience they gained by serving in combat. A paper that addresses specific changes and the way forward to incorporate and Combat and Operational Stress education would be value added to our military services.

Only four areas are mentioned here, though there are numerous other areas that warrant further research concerning this topic. These are the top area that warrant a future paper because of the usefulness they can provide to military and DoD. We can ill-afford to continue to be

reactive to combat and operational stress. Taking care of all our service members and their families is the standard by which all things should be weighed.

GLOSSARY⁶²

Abbreviations

BICEPS	brevity, immediacy, contact, expectancy, proximity, and simplicity
COS	combat and operational stress
COSC	combat and operational stress control
COSR	combat and operational stress reaction
CSC	combat stress control
CSR	combat stress reaction
DOD	Department of Defense
OIF	Operation Iraqi Freedom
PIES	proximity, immediacy, expectancy, and simplicity
PTSD	post traumatic stress disorder
RTD	return to duty

Definitions

Battle fatigue/combat stress reaction: produced by both physical and mental tasks. Unit leaders and medical and mental health personnel should assume that both physical and mental stressors are usually present in all unit personnel.

Brevity, immediacy, contact, expectancy, proximity, simplicity (BICEPS): an acronyms used for management of combat and operational stress reactions- *brevity* (usually less than 72 hours); *immediacy* (as soon as symptoms are evident); *contact* (chain of command remains directly involved in the Soldiers recovery and RTD); *expectancy* (combat stress control unit personnel expectation that the casualty will recover); *proximity* (of treatment at or as near the front as possible); *simplicity* (the use of simple measures such as rest, food, hygiene, and reassurance).

Combat and operational stress control (COSC): a coordinated program for the prevention of and actions taken by military leadership to prevent, identify, and manage adverse combat and operational stress reactions in units.

Combat and operational stress reaction (COSR): the expected, predictable, emotional, intellectual, physical, and/or behavioral reactions of Service members who have been exposed to stressful events in combat or military operations other than war.

Combat stressors: any stressors occurring during the course of combat-related duties, whether due to enemy action or from the soldier's own unit, leaders, and mission demands, or the soldier's home life.

⁶² These acronyms and definitions were taken from FM 4-02.51 (FM 8-51) and U.S. Army Center for Health Promotion and Preventive Medicine Issue 22-002-0499..

Mental fatigue: impaired performance due to continued mental effort on a specific task, whether it is a task requiring much thinking or constant attention. Emotions, such as boredom or uncertainty, also produce mental fatigue.

Mental stressor: one in which only information reaches the brain with no direct physical impact on the body. This information may place demands on either the cognitive systems (thought processes) or the emotional systems (feelings response, such as anger or fear) in the brain. Physical stressors can also be mental stressors if they are perceived as dangerous threats.

Physical fatigue: weariness and/or decreased performance capability due to hard or prolonged work or effort, muscle tiredness, aerobic fatigue, and sleep deprivation. Physical illness can also bring fatigue. Intense emotions also produce physical fatigue.

Physical stressor: one that has a direct impact on the body. It may be an external environmental condition (heat, cold, noise) or the internal physical/physiological demands on the body.

5 Rs: actions used for combat and operational stress reaction control that include—**R**eassurance of normality; **R**est (respite from combat or break from the work); **R**eprehend bodily needs (such as thermal comfort, water, food, hygiene, and sleep); **R**estore confidence with purposeful activities and contact with his unit; **R**eturn to duty and reunite Soldier with his unit.

Soldier restoration: a 24- to 72- hour (1- to 3-day) period in which Soldiers with combat and operational stress reactions receive treatment.

Stabilization: the initial short-term management and evaluation of severely behaviorally disturbed Soldiers caused by an underlying combat and operational stress reaction, behavioral health disorder, or alcohol and/or drug abuse reaction.

Stress: the mobilization of the body and mind to counteract stressors. It involves the physiological reflexes that ready the body for fight or flight. It also involves the mental reactions.

Stressor: any event or situation that requires a non-routine change in adaptation or behavior. It may pose a challenge to an individual's well-being or self-esteem. There are two routine types physical and mental. There are special types to include combat.

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